ATTACHMENT D

Subject: : Cordis / Medtronic Vascular Litigation, C.A. Nos. 97-550 and 97-700-SLR

From: SBalick [mailto:SBalick@ashby-geddes.com]
Sent: Monday, February 28, 2005 4:57 PM
To: 'slr_civil@ded.uscourts.gov'
Cc: Karen Jacobs Louden; Leslie A. Polizoti; 'rlupo@mwe.com'; 'dtanguay@mwe.com'; 'madavis@mwe.com'; 'munderhill@mwe.com'; 'jrizzo@mwe.com'; 'jingersoll@ycst.com'; 'jshaw@ycst.com'; 'cwright@ycst.com'; 'gbadenoch@kenyon.com'; 'cbrainard@kenyon.com'; 'abreneisen@kenyon.com'; 'mchapman@kenyon.com'; 'gldiskant@pbwt.com'; 'wfcavanaugh@pbwt.com'; 'emgelernter@pbwt.com'; 'kjlandsman@pbwt.com'; 'mjtimmons@pbwt.com'; 'sbhoward@pbwt.com'; 'reson@pbwt.com'; JDay
Subject: Cordis / Medtronic Vascular Litigation, C.A. Nos. 97-550 and 97-700-SLR

Dear Chief Judge Robinson:

By email of this date, Your Honor denied AVE's request for a conference in advance of the start of trial unless there are issues which may affect opening statements. In Cordis' view, there are no such issues.

Taking the issues raised by AVE in turn:

(1) Cordis' opening statement will not mention Dr. Ersek's compensation or the scope of his testimony. We assume the particulars that AVE wishes to discuss can be resolved at a later time.

(2) AVE seeks clarification of certain evidence relating to the alleged superiority of its products over the claimed invention and/or Cordis' commerical embodiment. Your Honor has ruled this evidence is inadmissible for purposes of infringment, but may be admissible if relevant to validity. We have advised AVE that Cordis will not rely on the commercial success of AVE's stents as evidence of nonobviousness, and will not accuse AVE of copying. This eliminates any possible relevance of any product-to-product comparisons or claims of superiority to the claimed invention under paragraphs (4)(h), (i), (k), and (m) of the Court's February 23, 2005 Memorandum Order (D.I. 1329) (the "Order"). For this reason, we expect AVE will make no such comparisons in its opening remarks.

(3) We will make no reference to the IP Worldwide Article in our opening.

(4) Cordis is not accusing AVE of copying and so, as your Honor has ruled, its patents are inadmissible. Order, paragraph 4(l). We have filed a brief today in response to AVE's brief on this subject.

Cordis believes that a conference would be helpful to discuss certain aspects of the Order, but that this could be accomplished on Friday after opening statements. We had previously agreed that witnesses would not

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:alled until Monday morning.

Respectfully,

Steven J. Balick
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ATTACHMENT E

WILCOX & FETZER LTD.

In The Matter Of:

Dr . Schatz Boyd Gary & Bradberry Spencie

Reel 2.1 of 2 EGPV000068

April 15, 1998

Wilcox & Fetzer, Ltd.
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Dr. Schatz 4/15/98 Boyd Gary & Bardberry Spencie Reel 2-1 of 2 EGPV000068.

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DR. SCHATZ: Our next patient is a 00:00:00
56-year-old gentleman with relatively recent onset of 00:00:01
angina. That was very classic. Dr. Bott on my right 00:00:05
here did a diagnostic angiogram and found this tight 00:00:08
lesion in the right coronary and a modest lesion in the 00:00:14
mid LED, an anomalus circumflex that comes off the right 00:00:16
coronary. 00:00:20
And our approach here is -- and you will see 00:00:22
in a moment here -- we are going to attack this right 00:00:24
coronary first. We just tried two wires, a stabilizer 00:00:27
and a PT graphics. And each one had difficulty getting 00:00:30
down there despite perfect guide position. So this thing 00:00:32
could be a lot tighter or more calcified than we think. 00:00:37
So we are going to go to our secret weapon 00:00:41
here, which is the shenoby (phonetic). Can I get a 00:00:44
transit? Okay. Here is the shenoby. That's the new 00:00:47
wire from Cordis for total occlusions. Get in there 00:00:53
first. This elema (phonetic) with side holes guiding 00:00:59
catheter is a Cordis 8 French. A little test shot there. 00:01:03
Good. 00:01:09
All right. So we've had two wires fail 00:01:12
already. So it makes this all the more testing. This 00:01:14
has been a phenomenal wire. It's got all the stiffness, 00:01:18
torque and lubricity that you need for totals. If it 00:01:21

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buckles a little bit or if it doesn't want to go, we'll 00:01:24
have to go to a backup with a transit just to give it a 00:01:27
little more column strength. So we will see what happens 00:01:33
here. 00:01:36
See, it's got nice tip rotation for a stiff 00:01:41
wire. It's nicely coated, a pretty good guide position 00:01:44
there. It's a lot tougher than we thought. It's a very 00:01:48
nice wire. Let's see if we can do it. If not, we'll 00:01:57
just go right to the transit. Let's have the transit 00:02:00
opened. 00:02:00
What's happening, we are losing a little bit 00:02:03
of our guide power. The guide is good, but it's not 00:02:05
really good enough. It's perfect. It's not quite 00:02:08
perfect. Let's have the transit. Okay. That's stuffed 00:02:12
right there. 00:02:19
All right. Take a deep breath there, 00:02:26
Spence, real deep. Test that. It's acting like a total. 00:02:32
He also has atrial fibrillation, which you can see, which 00:02:44
we are treating him for that as well. Put a little Cynie 00:02:45
(phonetic) on that. Hold that breath if you can. 00:02:48
Inject. Breathe away. Actually, I got down there a 00:02:52
little bit farther. 00:02:54
Now, when you see this much difficulty with 00:02:55
the wire, you should start to think about a rotor blade, 00:02:57

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which you might have to actually. There you go. All 00:03:01
right. Test that. Okay. That's a real tight lesion 00:03:05
there. We may have trouble getting a balloon across 00:03:11
there. So we may just have to drill this after all. We 00:03:20
may just have to. Test that, Brad. And I need a better 00:03:24
wire to torque it around up there. 00:03:31
Okay. We have the transit. And we will 00:03:32
switch this out for a regular wire, I think. Let's have 00:03:38
a stabilizer. We'll just switch this. 00:03:45
Now, if the transit doesn't go, then we know 00:03:48
we are going to have to drill this. But I'm quite 00:03:51
sure -- a regular stabilizer, yeah. As soon as this goes 00:03:53
across, I'll jump out and do that perk close over there 00:03:58
and you guys can start getting this set up. 00:04:01
Okay. Get on that wire, Jerry. Advancing. 00:04:10
Yeah. It's okay. Don't test them unless I ask you 00:04:23
because this will squirrel up my hands. That's pretty 00:04:27
hard. Okay. 00:04:37
Now, let's have our stabilizer and I'll put 00:04:38
a little bigger bend on it. Stabilizer. Okay. So I'll 00:04:42
put a little bigger bend on this. Okay. Let me switch. 00:05:12
Get on the other side of me here if you don't mind. Test 00:05:24
for me there with your left foot there. That's good. 00:05:28
Okay. Here we go. All I want to do is get 00:05:33

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this down past there and I'll use that big bend to stay 00:05:36
in the right coronary. Test shot there. There we go. 00:05:41
Okay. Our way out there. Okay. That's fine. 00:06:01
All right. Let's switch this. Run that 00:06:03
down. I will put tension on that and run that all the 00:06:05
way down there. Pick the Stabilizer XS next. Yeah, all 00:06:08
the way down. We'll switch it out. Good. Stop right 00:06:12
there. Stabilizer XS. Okay. Why don't you do that, 00:06:14
Jerry, get that down there and go ahead and do your 00:06:19
balloon? I have to break out of here for a second. Just 00:06:22
disconnect me and turn the tapes off. 00:06:25
Actually, keep -- oh, shoot. Gosh darn it. 00:06:27
We're taping this. Bloody hell. Just put everything on 00:06:32
Cynie there so when I come back we'll -- okay. 00:06:35
Okay. Take it up, 2, 4, 6. So like all 00:07:02
bare-stents, the minute it comes out, all the stents have 00:07:15
these little ribs on them and they are like speed bumps. 00:07:17
Each one has an opportunity to snag. So it could snag at 00:07:21
the ostium or anywhere along that length there. So if it 00:07:23
snags -- I'll put it in or I'll show you. But the minute 00:07:26
it snags, I'm going to stop because you can't really 00:07:27
force it. But at least you can see it and tease it back 00:07:30
in the guide. The trick is not to let it get out of the 00:07:33
guide. If you're having trouble with it, you don't want 00:07:36

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to be in that situation where it backs out. 00:07:37
Sinus rhythm again. Okay. That's a 3 00:07:42
millimeter by 30 Predator from Cordis. And deflate. All 00:07:46
right. Yeah, he converted the sinus. Yeah. Okay. 00:07:54
Good. We'll take another look here. 00:08:03
Dr. Bott and I were just talking about 00:08:09
benefits and risks of bare-stenting. We're going to try 00:08:10
a 22 millimeter Crown here. And the risk of snagging, 00:08:12
like with all the stents, the MultiLink and all the 00:08:15
others. Yeah. It looks a little better. So with the 00:08:19
bare-stents, you want to do a lot more pre-dilating 00:08:23
because of that snagging opportunity. So a little more 00:08:26
aggressive, loose and coming out. And even with the best 00:08:28
effort, you still can end up snagging. And worst case 00:08:32
bare-stent is embolization. So it can happen with all 00:08:35
the stents. All of them have that potential problem. 00:08:38
Okay. Switch again. Here is the Crown, the 00:08:41
22 millimeter Crown. Show it right there. It's a very 00:08:50
nice low profile. Let me check them a little bit to make 00:08:58
sure there are no snags. Sometimes they are a little 00:09:02
loose. But that feels pretty darn good. And you can 00:09:05
actually bend these a little bit to try and make the 00:09:10
curve. 00:09:12
Flexibility is not the issue here. It's 00:09:12

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always deliverability. You can have a very flexible 00:09:14
stent and not deliver it because it snags or embolizes. 00:09:16
The advantage of this, it's on high pressure balloon. 00:09:21
And, also, you can see it. So if it snags, at least you 00:09:22
should be able to retrieve it without getting into 00:09:27
trouble. 00:09:29
Having that said, of course, we have 00:09:30
embolized these. So just like all of them. Okay. And 00:09:32
that's a Stabilizer XS wire we have in there so it 00:09:43
straightens everything out. Okay. Advancing. Crowns 00:09:46
going in. Two markers. Take a real deep breath, Spence, 00:09:50
deep breath and hold it. A little snagging like we 00:10:04
predicted right there. Hold that breath if you can. All 00:10:09
right. And there it's snagging. Breathe normally. And 00:10:13
it's snagging right about, interestingly, where the 00:10:17
lesion was. So there is probably some calcium there. 00:10:19
Notice I've got the stent still inside the 00:10:23
guide. So if I want to come out, it's pretty easy. Slow 00:10:25
the cord. Just put in on Cynie. Inject. And what a 00:10:28
surprise, right at that section there. 00:10:35
So our choices are to dilate much more 00:10:37
aggressively with a bigger balloon for longer or go to a 00:10:40
different stent. A PSS I think would go down there just 00:10:44
fine. But I'm not going to push too hard here because I 00:10:45

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really don't want to risk embolizing this. Tension on the 00:10:48
wire. And that's just poor snagging. That's not a 00:10:51
flexibility problem. That's just pure snagging. 00:10:54
Real deep breath, Spence. Okay. I'm going 00:10:59
to go ahead and take it back. I'm still in the guide 00:11:00
there. So I'm just going to take it back. Retrieve it. 00:11:03
Yeah. All right. Because we have it blown open already 00:11:07
and trying to save a little money, we'll just try a real 00:11:11
aggressive balloon one more time. If that doesn't work, 00:11:13
we will switch to a different stent. 00:11:17
You still want a radiopaque one. The only 00:11:25
other option really, I think, is the AVE Microstent, 00:11:28
Microstent II or the GFX, which are good choices. I 00:11:31
wouldn't use a MultiLink here because of its 00:11:37
radiolucency. 00:11:41
Okay. Balloon again. There it is. Just 00:11:43
snagging right where you thought it would. Notice the 00:11:48
vessel's already recoiled there a little bit there. 00:11:51
That's the problem. So what we'll do, we'll do a nice 00:11:54
long inflation and be really fast try and get the stent 00:11:57
in there as quick as possible. Keep this Crown in the 00:12:01
bath here so it stays. All right. That's exactly what 00:12:05
happened to us yesterday. I told you. Do you remember? 00:12:16
Same thing. 00:12:19

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Oh, the other thing is put 2.15's in. Okay. 00:12:22
Advancing. It's not a bad option. But those can snag 00:12:26
also on each other. Okay. Pick it up. Test shot there. 00:12:33
Make sure I know where I am. Okay. It looks pretty 00:12:56
good. All right. Take it up, 2, 4, 6. Yes. Go to 8. 00:13:03
How hard did you go before on this? Okay. Good. Go to 00:13:09
10. All right. We're going to hold it there now and 00:13:14
hopefully get a little better. 00:13:16
Okay. So just basically you want a smooth 00:13:34
run in there. If you run your fingers on it, it feels 00:13:37
pretty smooth. But those little stickles of calcium will 00:13:41
just grab that. And it's just a problem. I guarantee 00:13:47
the old PSS would go right down there. We may have to do 00:13:50
that, since it's a Cordis case, just put the old PSS 00:14:00
down. Well, we could go to another stent. 00:14:03
All right. Okay. Now, what we want to do, 00:14:22
Lori, we want to replace this as quickly as possible. So 00:14:25
the second this comes out, have this flushed and ready to 00:14:27
go and we'll wire it as quickly as we can. Nice long 00:14:30
inflation there. Let it sit. What was the last one? 00:14:34
Yeah. Okay. ECT coming. What length is the GFX coming? 00:14:56
We only have one? Well, 3.5 by what? Well, it doesn't 00:15:17
matter. We only have one. 00:15:24
All right. I haven't tried that yet. I 00:15:27

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want to try it, but. We have some Microstents too. I 00:15:35
don't like those because they push too much. There is 00:15:40
too much cobblestone. But the trial looks pretty good. 00:15:42
I saw the numbers. And they look the same, so. 00:15:47
Okay. Deflate. Let's get it out as quickly 00:15:53
as possible. Go. Yeah. It's open. Yeah, it's open. 00:16:02
Good. You are out. Okay. Quick toot right there. 00:16:32
Okay. Let's have it down. Take a deep breath and hold 00:16:40
it there, Spence. Okay. A little better. Let's go 00:16:44
quickly. 00:16:48
Okay. What we are going to try to do is get 00:16:49
that stent down before it has a chance to recoil. So it 00:16:50
looks a little better there. We'll know in a minute if 00:16:54
we did it right. Otherwise, have some PSS's ready, 3.0 00:16:59
by 15's. Okay. Advance. Here we go. Okay. Spence, 00:17:06
take a deep breath. Same thing. Breathe normally. 00:17:27
Good. It just doesn't want to go. 00:17:35
Okay. Well, rather than risk it, let's get 00:17:38
a PSS. All right. Take it out. All right. Open up the 00:17:42
PSS. We're still in the guide there. So we can take it 00:17:46
out safely. The last thing you want is to be fishing 00:17:50
around for embololalic stents and coronaries. You have 00:17:54
an alternative here that's going to work. So why not 00:17:55
just do it? You could try 2.15 crowns also. But I think 00:17:59

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there is really not much advantage at this point. 00:18:07
Where was this now? Oh, if you want optimal 00:18:17
stenting. Oh, yeah, I already went there. That's right, 00:18:27
after I saw you, yeah. I thought it went pretty good. 00:18:29
Yeah. Some of those talks were good. Yeah. Well, I 00:18:31
load all my slides with that kind of stuff, and 00:18:39
especially now with all the competitive devices. All the 00:18:42
trials basically say they are equivalent to the PSS. So 00:18:45
there is no real huge advantage. Well, they don't 00:18:49
mention it. They don't care. It sort of comes with the 00:18:59
territory, yeah. 00:19:05
206? There we go. This ought to go right 00:19:21
down. Okay. We have a PSS here. Let's see if that will 00:19:24
go. Notice we didn't try too hard with that bare-stent. 00:19:30
There is no real reason why to struggle. If it's not 00:19:33
going, it's not going, you know. 00:19:36
Okay. Advancing. This ought to go pretty 00:19:39
easily. Deep breath, Spence. Snagging too. That's 00:19:41
interesting. Breathe normally. That's it. 00:19:59
Okay. So even though we have -- look at 00:20:07
that sheath. What happened there? What happened there? 00:20:09
That sheath got -- you see that? That sheath got slid 00:20:13
way down there. How did that happen? 00:20:17
All right. Let's take it back, make sure 00:20:21

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the stent is okay. Hold this together when it comes out. 00:20:22
Good. Go. Get the wire way back down. Push the wire 00:20:25
right now. What we are tying to do is get the wire back 00:20:31
down before we come out too far. Okay. Hold it. Now, 00:20:47
that's not the problem there. Okay. Switch. Let me do 00:20:55
that. It will be all right. I wanted to give him plenty 00:21:00
of insurance there. Okay. Loose and coming out. 00:21:04
Now, that's interesting. This thing is 00:21:10
completely jammed. All right. That's in the branch. So 00:21:11
just hold that just like so. And let's make sure that 00:21:24
everything is -- yeah, that's okay there. Loose, and why 00:21:29
this thing doesn't want to come out? The wire is 00:21:34
completely jammed inside the system. This is flushed and 00:21:37
everything? Look at that. Completely jammed wire. 00:21:40
Never seen that before. Yeah. Stuck. 00:21:45
All right. Well, it's too late now. It's 00:21:50
open. So make sure we don't lose the stent there. Stent 00:21:55
is fine. Yeah, it's fine. All right. Take that just -- 00:22:01
yeah, look at that. Just leave it like that. Okay. 00:22:07
Let's have another stabilizer real quick, please, before 00:22:11
we lose this switch again. First wire, yeah, get a wire 00:22:16
down there before it closes on us. 00:22:20
Stabilizer is fine. Well, how about that? 00:22:23
First time for everything. Stabilize as quickly as 00:22:25

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possible. Get a new one, new stabilizer, please, 00:22:33
quickly, warp speed. Well, strange where it's snagging 00:22:40
there. Well, we may have to go to something else. Mini 00:22:52
Crown -- I mean, Microstent. Well, we'll just dilate one 00:22:59
more time. That makes me a little suspicious. If the -- 00:23:04
yeah, it's just a big calcium slug there that's just in 00:23:13
the way. So I'm a little nervous now about the other 00:23:19
bare-stents. Torquer. Okay. Test. Very careful here. 00:23:23
Test, test, test. I should have put a bigger bend on 00:23:43
there. Same problem as before. Yeah. 00:23:47
Predator in the XS again. Probably need a 00:23:56
new one. Let's try the Iron Man. Let's be different. 00:24:00
Let's try the Iron Man. Cable in. Well, I'm surprised. 00:24:04
I really thought that with that extra dilatation, that 00:24:10
thing would go just fine. 00:24:14
Yeah, really well, too. 00:24:16
Well, that's calcium. There is calcium 00:24:19
there. I did think that the PSS would go. But I'll bet, 00:24:23
if we looked at another view of this dissection, I bet it 00:24:27
would be pretty nasty. I also think if we had drilled 00:24:30
this, we'd probably had a better lumen. It would have 00:24:33
been easier to stent. Advance. Yeah. 00:24:36
This is the Predator, right? Great. We'll 00:24:42
switch it out right away, Jerry. Watch for the XS. 00:24:46

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Yeah. It's okay. It doesn't need one. It might get in 00:24:55
the way. Okay. And coming back. You pull it and you 00:25:06
take care of it. All the way back to the guide. Yeah. 00:25:31
Good. Test shot. That's fine. All right, Jerry, hook 00:25:39
it up. 00:25:43
Okay. We are going to try dilating this one 00:25:48
more time aggressively, and then we may have to -- the 00:25:51
other thing that's got to go bigger, balloon, 3.5. Take 00:25:55
it up, 2, 4, 6. Yeah, may have to. 8, 10. 00:25:58
Start looking for a 3.5 by 20 Predator, by 00:26:08
20. We may just have to really aggressively bang that 00:26:12
spot to get everything airing out. Right. That just 00:26:17
tells you how much recoil there is. 00:26:24
This is the right strategy. You don't need 00:26:25
to drill this. You balloon it. You stent it. It's 00:26:28
going to come out fine. But if you can't deliver the 00:26:30
stent, then you should have drilled it. Let me see that 00:26:33
chief delivering VPS. Oh, we need a new one. That one is 00:26:39
all gummed up. Isn't this an Iron Man we have here? 00:26:44
Good. Yeah. All right. 00:26:49
Tell you what, just in terms of cost, let's 00:26:58
do this. Let's do this. Give me the Predator. If the 00:27:00
Predator works, it's going to be cheaper because then we 00:27:05
can use this Crown. So let me have the Predator, 3.5 by 00:27:08

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20 Predator. Opened. Do you have a 20? This strategy 00:27:10
has worked where we went back to a bigger balloon and it 00:27:31
went just fine. You just have to beat it up. You've to 00:27:35
get all the -- 10. He's so stable. It helps. 00:27:38
Okay. Deflate. Let's take it out. Take it 00:27:56
out. Yeah. Good. See it. Picture of it. See if it 00:28:01
looks different. Same. Okay. 00:28:36
Let us have the 3.5. This is going to work. 00:28:45
The risks are obvious. If you beat it up anymore, then 00:28:53
you can't stent it. Then you've got a real problem. But 00:28:58
we'll get something down there. I'm just trying to save 00:29:03
money here. It's against our better judgment. 00:29:06
Advancing. Isn't that true every time you try? Right. 00:29:09
Okay. Hook it up. Test shot there. I want 00:29:24
to stay right there. We don't want to get too far 00:29:30
downstream. A little experiment here. Test again to 00:29:34
make sure we're okay. All right. Take it up, 2, 4, 6. 00:29:40
Yeah, a little belly there. Do you see that? Go to 8. 00:29:48
Yep. Same spot where the wire had trouble. Same spot 00:29:52
where the balloon had trouble. It's calcified, hard. If 00:29:56
you look, it will show these little slide mites just 00:30:03
hanging down even though the luminogram looks reasonable. 00:30:08
A little gamble here. We are going to try 00:30:13
the Crown next, this 22 Crown that's been sitting over 00:30:15

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here. Flush out the central lumen. Good. Okay. So 00:30:17
once again, what we have done here is upsized our balloon 00:30:36
to get a little better lumen. These bare-stents you have 00:30:40
to get big lumen in order to get a lumen not snag. All 00:30:44
right. Deflate. Now, take it out as soon as you can. 00:30:48
Yeah. Yeah, open. Even though it's a 3.0, there is 00:30:52
going to be so much recoil. 00:31:00
Okay. So we are expecting quite a bit of 00:31:06
recoil even though that's a 3 millimeter Crown. If we 00:31:08
can deploy it, we can always upsize it if we think it's 00:31:12
necessary. But I think that vessel is really 3.0. The 00:31:15
medium might be 3.5, but the lumen is 3.0. good. You're 00:31:18
out. 00:31:24
All right. Quick picture. Looks the same. 00:31:26
All right. So that was 3.5. We didn't get much out of 00:31:36
it, all that recoil. Okay. Advancing. 00:31:40
All right. This is the same stent as 00:31:51
before. So we didn't burn up another stent. We've just 00:31:52
burned up 1 PS, before we start really spending a lot of 00:31:56
money here. Spence, deep breath and hold it, real deep. 00:32:01
Breathe normally. 00:32:08
It's a little closer, actually. It went a 00:32:10
little farther. Test shot. Inject. No. Same place. 00:32:13
Same place. No, that's a little dangerous because that 00:32:20

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stent could come right off. Spence, try a few coughs for 00:32:29
me. Cough a few times really hard. Good. Again. Okay. 00:32:32
Breathe normally. Okay. 00:32:38
Take it back slowly. Make sure it comes 00:32:40
back clean. Okay. Good. And that's radiopaque. You 00:32:42
can see the stents along there. All right. Let's try 00:32:48
the PSS one more time. 3.0. yeah. So because we are 00:32:50
having so much snagging, I still want the security of a 00:33:03
sheath system before I cave into the other bare-stent. 00:33:06
And my next choice would probably be the Microstent. 00:33:12
All right. Try the PSS. If that doesn't 00:33:17
work, we may just try the Microstent I. What are the 00:33:20
lengths on the Microstent? Do you have like an 18 or -- 00:33:26
you have a 3.0 by 9 and a 3.0 by 30? Okay. We don't 00:33:42
have much selection of that. The 30 might be too much. 00:33:50
In fact, we can use this measuring stick. That's 22 00:33:57
right there. And that's, basically, what we need. 00:34:04
Well, Jerry, we could try the 2.15 crowns. 00:34:05
The only problem is it's snagging right at the leading 00:34:10
edge. So whether it's 15 or 22, it shouldn't matter. 00:34:13
This is not flexibility. This is just pure snagging. 00:34:21
Okay. Load it. 00:34:39
Now, the other weird thing you could do is 00:34:50
drill this even now. Yeah. Oh, yeah, if all else fails, 00:34:53

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you could do that. There is probably a one millimeter 00:34:59
lumen there. It looks better now. But that's why this 00:35:02
stuff isn't going. So we may have to drill it. 00:35:06
Okay. Advancing. In fact, that might be 00:35:12
our next choice. Since we don't have all the right 00:35:20
AVE's. Spence, take a deep breath, deep breath and hold 00:35:28
it. Oh, same thing. That's just jamming right there. 00:35:31
That's a tight lesion. Okay. Take it out. Darn. 00:35:34
Breathe normally. Well, we did call it. We predicted 00:35:39
that was going to be the problem. 00:35:48
Okay. Now, thinking hats. We've done the 00:35:50
3.5. We can't go to 4.0. That would be ludicrous. So 00:35:51
our options are to try a bare AVE. But I'm telling you, 00:35:55
with all these snagging, I bet that will snag. I'm 00:35:58
thinking of drilling it. I bet there is a core lesion 00:36:01
right there that's much worse and has calcified. 00:36:03
Okay. Flush that really good. It might 00:36:09
need it again. All right. Let's have the balloon. 00:36:11
Let's change this out for a Type C. I think that's what 00:36:15
we are dealing with. We had several clues. The wire we 00:36:25
had trouble passing. The balloon had trouble passing. 00:36:29
So I know it's a big chunk there. And we're not doing 00:36:32
definitive rotor blade here. We're just trying to smooth 00:36:36
it out. 1.75 or maybe even a 2.0. Yeah. Now, there is 00:36:38

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a sizable -- I'll guarantee, if you did ultrasound, you 00:36:42
would see a big chunk there. 00:36:46
Let's have a Type C and let's put a 00:36:48
pacemaker in. Okay. Advancing. Get us a Type C. And 00:36:50
get us a pacemaker set up. We'll pace him. Get the 00:37:05
Cardizem on board. Who knows what he'll do. Okay. 00:37:10
Yeah. Type C. Okay. 00:37:17
Well, this is turning out to be very 00:37:20
interesting. Dr. Bott, it seems to me your last two 00:37:22
cases have been very interesting. In fact, they were 00:37:25
carbon copies, late night cursing Dr. Bott. What the 00:37:28
heck did Sam do? Careful on that. Don't stretch that 00:37:32
ribbon. All right. It looks all right. All right. 00:37:47
Okay. Now, size. The Predator doesn't take 00:37:53
the Type C very well. I forgot that. Do you remember it 00:38:09
drags? There's going to be wear down there. It's not 00:38:13
coated. And I forget. This is an old balloon. It 00:38:14
doesn't have good coating. So this drags in it. It's 00:38:18
not coated, so, one, don't bend the wire. Good. Right 00:38:21
there. That's the problem, just very short. It will go. 00:38:25
It's just a nuisance. I forgot about that. I should 00:38:33
have used the transit. That's the right technique. 00:38:38
You can start bringing it back. There will 00:38:45
be a break point. It will start coming. Okay. Jerry 00:38:48

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will get that pacemaker in. In fact, let me work on 00:38:55
this. You get to start working on the pacemaker. Put a 00:38:57
pacemaker in, Venus sheath in. 00:39:10
Where did you do your fellowship Sam? 00:39:21
That's a good program there. Good. It's got lots of 00:39:24
volume there. Nice guys up there. They were going to 00:39:30
close but now it's open. Right. That's what I thought. 00:39:32
So they are open for business. 00:39:45
The pacemaker is in. The minimum, the 00:39:56
minimum sheath for whatever. 5. Coming out. Give 00:40:04
another thousand of heparin. Yeah. Make it 2000 in 00:41:01
fact, 2000. We'll keep an eye on that clock for you. 00:41:15
It's what, 9? Okay. That's a very interesting problem. 00:41:37
We were dilating like crazy and nothing will go. Right. 00:41:50
Well, you know, what we were trying to do 00:41:55
was save time and save money. And now here we are, going 00:41:57
to spend another couple thousand dollars. Oh, no, just 00:41:59
balloon it, the minimalist, the minimalist 00:42:03
interventionalist. So but, you know, sometimes that 00:42:06
strategy works. Good. Now we've got the cost really 00:42:09
going up. Got the pacemaker, got multiple burs, now 00:42:16
wires, burned up two stents, now are going to get 00:42:20
trashed. 00:42:23
Another funny thing about our business now 00:42:26

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is this perseverance because you know darn well if you 00:42:28
get it there, it's going to look great. It will be 00:42:32
perfect. And he will do very well. 00:42:35
His pressure is down a little bit. I think 00:42:40
it's the guide being stuffed a little bit. So I think 00:42:41
it's okay. See if that pacemaker opened. He will feel 00:42:45
better. Uh-huh. That's hanging up on something there. 00:42:49
Take a deep breath, Spence. 00:43:36
Now, I don't like that. You've got some 00:43:39
PVC's there so. It's trying. PVC's. It's not going to 00:43:46
be stable there. Well, loop it up in the atrium. It's 00:44:13
okay. Pretend like it's a pulmonary. That's probably 00:44:43
coronary sinus there. I don't like that. Watch that. 00:44:48
Just try a quiet place. We'll test it. It's not great. 00:45:09
He may not even need it, so. Okay. 00:45:16
Do you do some EP also on pacemakers and all 00:45:36
that? Yeah, that's the guide. Just disengage the guide 00:45:40
to test it without losing the wire. Yeah. There it 00:45:44
goes. There you go. Okay. Yeah, just stuffed against. 00:46:00
Okay. Test the pacemaker. Put it at the 00:46:05
rate of about 110. That's fine. That's fine. Okay. 00:46:09
Turn it off. That's fine. Okay. Let's cover that up. 00:46:12
Towel. 00:46:17
All right. Let's go. Let's do a 1.75. 00:46:18

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Let's be conservative. I'll know by how much resistance 00:46:23
that's passing there. Yeah. The whole idea is it's 00:46:34
cheaper. But they charge so much for it that it really 00:46:53
doesn't save anything. It's hard. It's not that easy to 00:46:56
do. 00:47:32
Flush, flush. Straighten it out. 00:47:48
Straighten it out, please. Okay. Ready to test. Wire 00:48:08
clip. Where did that come from? 150. Good. Okay. Go 00:48:18
anytime. Yeah. That hasn't changed. Just learned how 00:48:43
to deal without damaging the wire a little better. 00:48:59
Hundred and hundreds of cases now. So just a little more 00:49:02
jitterbug action usually gets it down there. Okay. 00:49:05
Now, if there is no resistance, we will have 00:49:17
to go right up to a 2.15. Okay. Ready? Wire clips on? 00:49:20
Pacemaker's ready? Not much. Pull it back a little. 00:49:23
I'm too far in. Just pull. One more time. Okay. A 00:49:28
little bit, two to one. Pacer. Good. Take the rate 00:49:43
down slowly. He should come out of that pretty quick. 00:49:51
Good. There we go. Okay. Lull coming out. 00:50:00
All right. Because I don't want to waste a 00:50:17
step, let's go right to 2.0 bur. I don't want to have to 00:50:19
go through a balloon and a multiple -- let's just do it 00:50:27
now. Let me see it. It might be a 2.15. Let me see how 00:50:32
big it is. Yeah, let's have a 2.15, the Philmonte 00:50:39

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(phonetic). Yeah. I use the old Phil. So I don't know. 00:50:55
Actually, that looks better. Doesn't it? Yeah. Well, 00:51:03
we will do this and we will put the 3.5 balloon Nexcelby 00:51:15
(phonetic). And then we'll try the current. It will be 00:51:20
all right. It's never easy. 00:51:24
Actually, we had an easy one the other day. 00:51:31
Didn't we? We had -- it was memorable. Mr. Murdock, Ed 00:51:34
Murdock, he had about a 25 millimeter lesion graft and we 00:51:43
put a 30 millimeter Crown. It took like seven minutes. 00:51:45
LD, what are you doing? 00:51:49
I read a great editorial this week in the 00:52:10
circulation once again saying we are stenting too much. 00:52:12
Provisional stenting only. Well, that's my new slide now 00:52:19
is provisional Reel Pro, only when you need it. 00:52:28
It's banging on something. There we go. 00:52:45
That's banging on everything in there. We're going to 00:53:02
move it around. He can take it out and move it around a 00:53:16
little bit. He's probably just trapped. It was trapped 00:53:19
in there. It's okay. Here we go. Go. Two more 5's. 00:53:35
Stop and go, tap, tap. Good. Okay. Size, go and go. 00:54:05
It's big. Wire clip. Good. Flow. Too much tension. 00:54:18
Pull it back. Good. One more. Wire clips on. That 00:54:28
sounds horrible; doesn't it? Pacer. Let me unplug it. 00:54:35
Flow, flow. Loosen it up. Pull it out. Pull it out. 00:54:47

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Pull it out. Pull. All right. Good. There's a little 00:54:50
flow down there. 00:54:52
Okay. Slow the rate down. Slow the rate 00:54:55
down. That's going to be good. Yeah. Okay. That's 00:54:57
just right. Lucent coming out. Here we go. Okay. 3.5 00:55:10
balloon and then a Crown and hopefully that will -- what 00:55:29
does that mean? I don't follow. You mean turn it on? 00:55:33
Yeah, we do it here before it goes in. We don't do it 00:55:48
inside there. Yeah. 00:55:52
Okay, let's have -- right. Yeah, use the 00:55:53
transit. Then use the Predator. Use the transit. Then 00:55:59
on the XS, get a picture. All right. Good. Pacemaker 00:56:02
can come back. Turn the pacemaker off. Put in the IVC 00:56:17
in case we need it. I don't think we will. Great. 00:56:24
Bookbinders' first rotor blade that he did 00:56:27
here, he did a wild case. It took forever and sent the 00:56:29
guy upstairs and the guy arrested. And he had 00:56:35
(inaudible), not from the rotor blade but from the RB 00:56:37
Pacer. And the guy fibrillated on the table and they 00:56:46
shocked him with the RB Pacer in it and it shocked him. 00:56:46
Ever since then, take it out. Yeah. I heard about it 00:56:47
but I had never seen it. 00:56:57
We are getting there folks. We are getting 00:57:00
there. Now that we've got a transit, we are going to 00:57:01

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switch this wire out for an XS and we'll do our sequence 00:57:06
again of ballooning. Can we have the pedals? Get rid of 00:57:13
that orange one. Yeah, Iron Man is fine. Okay. Go. 00:57:15
Good. Iron Man. 00:57:42
Okay. Sam can't say we didn't try 00:57:45
everything. We are going to try everything for you here. 00:57:49
Loose. Coming out. All right. Try the 3.5 balloon. We 00:57:59
are going to do the Philmonte here, the 3.5 and the Crown 00:58:03
is going to go right in. Balloon. This is a very weird 00:58:08
case, very weird. You can do the balloon part. Yeah. 00:58:22
Well, it's a good lesson. It's great for taping, too. 00:58:29
We will be able to teach a lot with this one. 00:58:32
He's a perfect patient for this, too. He's 00:58:34
so funny when I talked to him yesterday. He's so 00:58:37
entertaining. He was so eager to talk. I could hardly 00:58:40
get anything in. He was talking about his fishing and 00:58:44
camping. 00:58:47
It looks better. It's amazing what we do to 00:58:58
coronaries and some of these hearts. I just reviewed 00:59:10
this tape that John Abley made from September ago. We 00:59:13
all gathered in Switzerland for the 20-year anniversary 00:59:17
and tribute to Andreas Gruentzig. It's his first case. 00:59:24
And he sort of memorialized the whole thing by having a 00:59:26
nice tape of made of interviewing all us about the early 00:59:29

days of angioplasty. 00:59:33
It was fun because they had tapes of 00:59:36
Gruentzig in the early days, 1981. That first course 00:59:37
that he did, I was there. And I remember. It was so 00:59:38
funny because -- go ahead. Take it up, 2, 4, 6. When 00:59:42
you just do this, people in the audience would see NVFT's 00:59:48
go up and they start yelling, take the balloon down. 00:59:53
Take it down. It's really funny. It's like scary, you 00:59:58
know. Invariably, two or three people would end up with 01:00:00
surgery. Horrible. Horrible. The guides worked 01:00:07
terrible. 01:00:11

State of Delaware)
)
County of New Castle)

CERTIFICATE

I, Anne L. Adams, Registered Professional Reporter and Notary Public, do hereby certify that the foregoing record from DVD, in its entirety, is a transcript of my stenographic notes.

IN WITNESS WHEREOF, I have hereunto set my hand and seal this 3rd day of March, 2005, at Wilmington.

Anne L. Adams
Certification No. 105-RPR
(Expires January 31, 2008)

ATTACHMENT F

In The Matter Of:

Schatz Patient Bradberry, Spencie

Schatz Patient Bradberry, Spencie

April 15, 1998

Wilcox & Fetzer, Ltd.
Phone: 302-655-0477
Fax: 302-655-0497
Email: lhertzog@wilfet.com
Internet: www.wilfet.com

"SCHATZ 4/15/98 PATIENT BRADBERRY, SPENCIE"

DR. SCHATZ: One case that I couldn't get 20:39:31
the balloon across or right, I actually took the 20:39:31
balloon out and got some mineral oil, like WD-40, and 20:39:31
coated the balloon with it and ran it right down. It 20:39:31
went right down. 20:39:31
Even nitro, intracoronary nitro. We have 20:39:31
to make it ourselves. You take a nitro tablet, grind 20:39:31
it up, then mix it on the table with some saline, then 20:46:09
pour it through a millipore filter. 20:39:31
Okay. Advancing. Yeah. 20:39:31
Little things like that. 20:39:31
Quick test. Let me take a test shot 20:40:20
there, see where we have to go. Yeah. My fault. I 20:40:20
wasn't tight. Sorry. That was my fault. Yeah. 20:40:20
All right. Well, that's it. That's where 20:40:28
we're going. 20:40:28
Take a deep breath there, Spence, a deep 20:40:28
breath and hold it. 20:40:31
What? We're taping. Oh, yeah. Come on. 20:40:35
Neutral. Neutral. All right. 20:40:38
Look at that. What is it hooking up on? 20:40:42
Watch it. There you go. 20:40:49
Spence, take a real deep breath. 20:40:51
Try pulling on it. Sometimes a little 20:40:54

straighter shot ... That doesn't work. 20:40:56
Breathe normally. Breathe. 20:40:59
Okay. Well, take it out. Let me get it 20:41:02
before to make sure it's engaged there nicely. All 20:41:07
right. Now, it might be hooked there. There you go. 20:41:11
Yeah. Okay. Like 0 for 5 here. 20:41:13
Do you have that PSS still? Let's have 20:41:21
that. And if all else fails, we'll try the AVE. 20:41:25
Good. Still there. Still hanging in 20:41:30
there. Starting all over. 20:41:32
We have examples with both. We have one 20:47:57
where the Crown wouldn't go. Then we have some where 20:48:00
nothing would go, but a Crown. So they're all the 20:48:04
same. 20:48:07
All right. Last chance motel here, guys. 20:48:11
All right. So what do we have for AVE? 20:48:16
That's 20 or 18 milli -- do we have a 3.5? What 20:48:18
length? 20:48:24
All right. That will be next. If this 20:48:27
doesn't work, that's what we'll do next. 20:48:29
Do you have a 3.5 by 18 GFX? All right. 20:48:33
That will be the next one. Don't open it yet. Just 20:48:39
have it ready. 20:48:54
That's visible. Isn't it? You can see 20:48:57

that one. Pull. 20:49:05
Okay. Here we go. Advancing. 20:49:05
Okay. Tension on the wire. There we go. 20:49:16
Poof. All right. 20:49:25
Yeah. Well, it wasn't easy, but it did 20:49:29
go. 20:49:31
All right. A quick test to see if we're 20:49:32
in the right place. Yeah, it's good. Okay. That's 20:49:34
fine. All right. 20:49:37
Definitely, yeah. All right. That was 20:49:41
just a flap. I think it was just sticking on it. 20:49:49
All right. Bring it back. Hook it up 20:49:55
there. The old PSS to the rescue. 20:49:57
I know. Well, some accounts, the 20:50:03
salespeople tell me they're forcing them. We don't 20:50:04
want them, we don't want them. But in fact, the day 20:50:07
we put our -- yesterday, Paul had to put one in over 20:50:09
there, yeah, in the other room. 20:50:12
Yeah. Test. All right. That's good. 20:50:14
Take it up 2, 4, 6. Go. Little spasm and pseudo 20:50:16
stenosis there. Good. Great. Deflate. 20:50:23
Okay. Now, this is -- yeah. Yeah. Yeah. 20:50:37
Yeah. We'll see. We might want o -- we 20:50:50
could put a Crown in here. We could do almost 20:50:51

anything. Now, it doesn't matter. So we might as 20:50:54
well go with a Crown, maybe. 20:50:57
Good. You're out. 20:51:00
All right. Test shot there. Inject. 20:51:04
Good. That distal is looking whimpy. Isn't it? 20:51:12
It's probably a little -- combination of 20:51:18
pseudo stenosis. We'll probably have to fix that. 20:51:20
All right. We'll see. 20:51:27
Proximal looks like what? Hold on. 3.0. 20:51:28
Let's have a 3.0 by 15 Crown. See if it will slip 20:51:36
past there. I hope it does. 20:51:39
Telescoping the Crown is not easy either. 20:51:41
Sometimes it bangs. 20:51:44
I would try a Crown, but -- knowing that 20:51:51
it could snag. 20:51:54
No. I would just gamble and try and do it 20:52:05
all at the end. No. We really should -- I think we 20:52:07
probably ought to end up fixing that. Why not? All 20:52:10
this work and ... We might be able to slip it down 20:52:13
there without predilating. It's possible. In fact, 20:52:16
if this goes -- flies, then just let it go, see if it 20:52:19
will get there. 20:52:25
Now, Paul has had a few of these slide off 20:52:26
in his hands here. So I always check. I have not 20:52:29

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seen that. He claims he's had some slide right off. 20:52:30
I don't believe it, but. 20:52:34
Okay. Here we go. Advancing. This is a 20:52:37
3.0 by 15 Crown. 20:52:38
Terry, if this goes easily, I might slip 20:52:43
it down to that distal lesion. We'll see. Okay. 20:52:46
Take a deep breath, Spence. 20:52:51
Yeah, it's snagging down there. I'll just 20:52:55
take care of the ostium and get ready -- 20:52:57
Breathe normally. Breathe normally. 20:53:01
Test that. Okay. Got a lot of overlap, 20:53:06
but that's okay. Saw that coming. 20:53:13
Test that. Okay. That's looking a little 20:53:19
better. Hook it up so we'll be ready to roll. All 20:53:24
right. Let's at least get that taken care of. Then 20:53:29
we can decide about that distal stuff. 20:53:32
Okay. Test again. All right. I'm going 20:53:38
to try and scoot it out there. Center it. That's 20:53:43
good, Jerry. Test that. That's actually pretty good 20:53:46
there. Yeah, it's one of those all-or-nones. 20:53:56
Okay. Test that. That's not bad. Test 20:54:11
that. Once more. One more test. I think that's 20:54:25
good. I don't mind if it's dangling a little bit. 20:54:32
That's ... Test that. 20:54:37

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That's all right. Take it out. I think 20:54:43
the guy just popped back up. That's all right, 20:54:46
though. 20:54:46
Take it up. Go to 16. It will be all 20:54:49
right. 20:54:52
Okay. Deflate. 20:54:57
All right. All right. Well. That's 20:55:03
good. Yeah, that's fine. 20:55:06
(Indistinguishable.) 20:55:06
DR. SCHATZ: I forgot about that. Good 20:55:24
point. 20:55:43
Okay. Inject. Good. 20:55:47
I think so, yeah. 20:55:47
All right. Now, decision time. That 20:56:01
could be a gap between the two stents also. All 20:56:08
right. Let's move forward. 20:56:11
Let's make a decision about that distal. 20:56:13
All right. Now, the other stent has to be 20:56:18
dilated anyway because it's underdilated. 20:56:21
All right. Let's decide if we're going to 20:56:25
go after that or not down there. What do you think? 20:56:28
It will probably look a lot better, I think. 20:56:32
All right. 20:56:36
Combination -- that is also a part of the 20:56:40

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wire. Now, there -- well, there was something there. 20:56:41
Yeah, we talked about that from the beginning. 20:56:44
Let's have a 3.0 charger. We will 20:56:46
predilate that. 3.0 by 15. We'll dilate that 20:56:49
section. Postdilate that. And then try and get 20:56:54
another Crown down there. 20:56:57
Yeah, might as well. We have to predilate 20:57:00
anyway. Predilate. Then postdilate. Give us the 20:57:02
best chance, yeah. A-million-dollar case here. 20:57:08
This week he is going to cook for us, get 20:57:21
some hot cakes going. 20:57:24
Okay. What we've decided to do here is, 20:57:26
we're going to dilate now. This mid-section looks a 20:57:29
little, a little stenotic, now that we have everything 20:57:33
else fixed. So we're going to put a 30-0 charger in 20:57:38
there. Predilate that. Postdilate the existing PSS 20:57:38
stent and then get another Crown down there, 20:57:40
hopefully. 20:57:42
Okay. Advancing. Here we go. Okay. 20:57:43
Hook it up. Take the tube there. Test shot. Coming 20:58:05
in. There we go. Test. All right. That's good. 20:58:12
All right. Take it up 2, 4, 6, 8, 10. 20:58:18
There is a lesion there. 12, 14. Yeah. 16. It's up 20:58:23
there, too. 20:58:28

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What are you at? Go to 18. Deflate. 20:58:29
Yeah. Well, actually Sam mentioned that 20:58:36
at the beginning if we were going to fix that. I 20:58:36
tried to talk him out of it. 20:58:39
Okay. Let's do that stent now. Test 20:58:41
shot. 20:58:44
Okay. Take it up 2, 4, 6, 8, 10, 10, 12, 20:58:46
14, 16. Good. Deflate. 20:58:54
All right. Take that out. Take a 20:59:02
picture. Okay. All the way out. That's a 3.0 20:59:03
charger coming out. 3.0 by 15. 20:59:12
Okay. Good. All right. We'll take a 20:59:21
picture and then we'll decide if it should be a 3.0 20:59:29
Crown, 3.0 by 15 Crown. 20:59:33
Inject. Yeah. A little split. All 20:59:37
right. 3.0 by 15 Crown. 20:59:43
We got that 22 here. Maybe we ought to 20:59:47
use that. 20:59:49
Oh. Get my tape ready. I want to tape 20:59:50
this one. 20:59:52
(Indistinguishable.) 20:59:52
DR. SCHATZ: That was a 15 up there. That 20:59:57
is pseudo stenosis up there. When the wire comes out, 21:00:11
it ought to relax. It probably is a gap, but it's not 21:00:15

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going to hurt us, I don't think. 21:00:19
(Indistinguishable.) 21:00:19
DR. SCHATZ: Yeah. 21:00:35
UNIDENTIFIED SPEAKER: How are you doing 21:00:35
there, Spencie? 21:00:35
UNIDENTIFIED SPEAKER: Good. Very good. 21:00:48
DR. SCHATZ: All right. Some people you 21:00:48
can just tell are going to be absolutely wonderful. 21:00:49
No problem no matter what. 21:00:56
All right. Advancing. Okay. This is a 21:00:56
15 millimeter Crown, 3.0 by 15. Try and touch up that 21:00:57
mid-section. 21:01:02
Take a deep breath, Spencie. 21:01:03
It's banging into the other PSS, yeah. 21:01:07
Oh, darn. 21:01:12
Breathe normally. 21:01:14
All right. Take it out. Yeah. Drat. 21:01:22
Okay. Well, this would be a good time 21:01:29
for a, yeah, a GFX. 21:01:31
All right. Now, 3.0 -- we only have a 9 21:01:38
and a 30. Right? So it's going to have to be a 3.5. 21:01:40
(Indistinguishable.) 21:01:40
DR. SCHATZ: Well, is it a 3.5 or is it a 21:01:47
3.0 down there? 21:01:49

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(Indistinguishable.) 21:01:49
DR. SCHATZ: Well, I don't know. It's the 21:01:59
first time -- we may have to do this whole segment 21:02:01
there. I don't know. Where is the other stent in? 21:02:03
Let's see. 21:02:07
UNIDENTIFIED SPEAKER: Right at the 21:02:07
branch, I think. 21:02:07
(Indistinguishable.) 21:02:09
DR. SCHATZ: Right there, I think, maybe. 21:02:09
Or, no, or right there. Right there, right there. 21:02:10
That's it right there. You can see it. It's ghosting 21:02:12
right there. So we, basically, have to pick up that 21:02:15
hump. 21:02:15
Let's get a Microstent, a 3.0 by 18 21:02:18
Microstent. 21:02:23
We don't have that. Okay. Fine, fine. 21:02:25
3.5. Let's have a 3 -- 21:02:27
Now, the GFX, I'm sorry, what length do 21:02:30
you have? 21:02:33
(Indistinguishable.) 21:02:33
DR. SCHATZ: Okay. Let's take that. It 21:02:34
used to be easy. It was one. Now I have to know them 21:02:38
all. 21:02:38
All right. 3.5 by 18 GFX. 21:02:38

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(Indistinguishable.) 21:02:38
DR. SCHATZ: Well, that's deeply 21:02:45
difficult. I've had good luck with Microstent 2s 21:02:49
going through other stents. Yeah. 21:02:58
How many atmospheres does this balloon 20:03:01
take, the GFX? 20:03:04
(Indistinguishable.) 20:03:06
DR. SCHATZ: Okay, okay. Let me see what 20:03:06
it looks like there. 20:03:08
Okay. Here we have a GFX, 3.5 by 18. 20:03:10
Okay. Let's do it. 20:03:17
It's a wild case. 20:03:39
Oh. We have to tape this. Scroll forward 20:03:49
to number 1. Are we already erasing? 20:03:53
(Indistinguishable.) 20:05:31
DR. SCHATZ: I want you to scroll forward 20:05:37
to number 1. You want me to tap? Okay. Sorry. Go 20:05:39
ahead. I don't think I can erase anything on this. 20:05:43
All right. Sorry we have to delay here to 20:05:47
get this on my tape. It's always something. 20:05:52
Okay. Put my tape in and let's record 20:05:54
right from here. Go ahead. 1 to 29. Do it. The 20:05:56
rest is lost forever. 20:06:01
It's funny. It would not look like a 20:06:09

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tough case, you know. 20:06:11
(Indistinguishable.) 20:06:11
Yeah, in the old days, you would balloon 20:06:15
it, you would be in surgery, and that would be it. 20:06:16
Yeah, those demonstration courses, it's 20:06:21
not unusual to see lots of de-tach, lots of defib, 20:06:23
lots of CPR. Hartzler, especially, would say he would 20:06:27
have one or two deaths out of ten or 12 cases that he 20:06:33
would do. 20:06:37
(Indistinguishable.) 20:06:39
DR. SCHATZ: Hey, wait. Is there a 20:06:59
billing code for that? Did we convert him? 20:06:59
(Indistinguishable.) 20:06:59
DR. SCHATZ: Yeah. Is that cardizem off 20:07:14
now? 20:07:17
UNIDENTIFIED SPEAKER: It is.
DR. SCHATZ: Okay.
(Indistinguishable.)
DR. SCHATZ: Yeah. Good ahead and do it
right now.
Okay. ACT coming. 20:07:42
It seems pretty flexible. A little 20:08:24
unction. A little unction. 20:08:48
(Indistinguishable.) 20:08:48

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DR. SCHATZ: Okay. Mm-hmm. Oh, yeah. I like that idea. Is there a billing code for that, is the question? 20:08:49 20:08:52 20:08:55

(Indistinguishable.) 20:08:55

DR. SCHATZ: Okay. All right. Here we go. This is a 3.0 by -- 3.5 by 18 GFX. 20:08:57 20:09:00

The moment of truth. Will it pass or nothing else will go? 20:09:10 20:09:12

Take a deep breath. 20:09:16

Oh, look at that. 20:09:19

That's pretty impressive, you've got to admit. Hook it up. That's impressive. That's impressive. I think that's because it's round. It's not sharp. 20:09:20 20:09:24 20:09:28 20:09:31

Test any time. 20:09:34

(Indistinguishable.) 20:09:34

DR. SCHATZ: Yeah, test. It will be all right. It's a pretty big vessel. 20:09:40 20:09:42

All right. I think we got it there. 20:09:44

One more test. 20:09:48

I don't know if there is a gap there in that other one. Do a high res. and we'll see it. 20:09:52 20:09:54

Take a deep breath, Spencie. Take a deep breath and hold it. 20:09:58 20:10:02

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Inject, inject. Take it up 2, 4, 6. 20:10:03

There might be a little gap there. I don't know. 20:10:08

Good. 8, 9. Deflate. 20:10:11

Now, you have to do high pressure with this, too. Take it up. 20:10:21 20:10:23

(Indistinguishable.) 20:10:23

DR. SCHATZ: Is that true? They don't recommend coming back with another ... Is that true? 20:10:27 20:10:28

(Indistinguishable.) 20:10:28

DR. SCHATZ: Well, now that we have wall-to-wall metal, we might as well take advantage of it and put a 3.5 in there and just pound the whole thing. We'll probably have some gaps there because I'm not sure we really telescoped it. 20:10:35 20:10:37 20:10:41 20:10:45 20:10:49

(Indistinguishable.) 20:10:49

DR. SCHATZ: Yeah. Sure. Yeah. Absolutely. Just dial 9. A phone in any room there. 20:10:35 20:10:53

(Indistinguishable.) 20:10:53

DR. SCHATZ: Okay. We'll keep banging away on this LAD. I guess you -- do you want us to do that? Or do you want to do that up there? 20:10:35 20:11:02 20:11:04

(Indistinguishable.) 20:11:04

DR. SCHATZ: Well, we might as well try it, I guess. We'll take a look at it. 20:10:35 20:11:09

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(Indistinguishable.) 20:11:09

DR. SCHATZ: That's nice. Let's have a 3.5 by 30 charger. We'll do the whole segment. 20:11:11 20:11:16

(Indistinguishable.) 20:11:16

DR. SCHATZ: Okay. Give another 2,000 of Heparin. Well, the GFX gives a nice appearance. I like that. 20:11:11 20:11:31 20:11:42

(Indistinguishable.) 20:11:42

DR. SCHATZ: Yeah. You can still see the little cobble-stoning, though. 20:11:50 20:11:52

(Indistinguishable.) 20:11:52

DR. SCHATZ: All right. This will smooth it a lot, though. 20:11:11 20:12:00

3.5 by 30. Right? 20:12:04

(Indistinguishable.) 20:12:04

DR. SCHATZ: How much contrast did we use? 20:11:11

(Indistinguishable.) 20:11:11

DR. SCHATZ: Okay. Advance. You can see the stent. 20:11:11 20:12:51

All right. Take it out 2, 4, 6, 8, 10. That's good. I'm purposely keeping it out of the distal. 12, 14. Deflate. 20:12:53 20:12:58 20:13:00

All right. Do this whole proximal section. Get a little more aggressive. Okay. 20:13:13 20:13:15

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Test shot there. Yeah. 20:13:27

All right. Take it up. 10, 12, 14, 16. Good. Deflate. All right. 20:13:31 20:13:41

UNIDENTIFIED SPEAKER: Spencie, how you doing? 20:13:51 20:13:52

DR. SCHATZ: Okay, Spence, you're doing really good. We're pretty much done here with this one. 20:13:53 20:13:55 20:13:59

(Indistinguishable.) 20:13:43

DR. SCHATZ: Okay. Sorry about that. 20:14:03

Good. Done. 20:14:19

That's good. 20:14:34

All right. We'll take this wire out. See what that looks like. 20:14:35 20:14:37

Breathe normally. Nice, easy breaths. 20:14:39

Yeah. Let's do it without the wire. Let's get all those curves out. 20:14:48 20:14:52

Deep breath and hold it again. Good. Don't breathe and don't move. 20:14:55 20:14:57

Inject, inject. That's good. 20:14:58

Breathe away. 20:15:02

All right. That's going to be a final. 20:15:04

1 goes with that. So 1 and 35 go together. 20:15:07 20:15:11

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Deep breath and hold it. Don't breathe 20:15:12
and don't move. 20:15:16
Inject. 20:15:23
And breathe. 20:15:23
All right. Good. That's fine. 20:15:23
All right. Well, I think I'd rather leave 20:15:26
it. Kind of tired. There is no guarantee that would 20:15:36
be smooth either. That could be a marathon if it 20:15:39
doesn't work right. 20:15:43
Okay. Let's take a quick look at it. 20:15:44
Maybe we'll ... Let's have a JL 4. 20:15:47
(Indistinguishable.) 20:15:52
DR. SCHATZ: No. I think it looks modest. 20:15:55
He can do that up there. I'm just kind of tired. I 20:15:59
don't feel like dealing with this, another two hours 20:16:04
of this. 20:16:06
Okay. Those are our final pictures. If 20:16:07
you can get us some printouts of those. 20:16:09
UNIDENTIFIED SPEAKER: Spencie, you are 20:16:12
holding up okay there? 20:16:14
DR. SCHATZ: Let me tell you, we finished 20:16:18
the right side. It came out absolutely beautiful. We 20:16:19
just have to decide if we're going to fix the other 20:16:19
one. We've have been here for a long time, and you've 20:16:23

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had a lot of contrast. We may just fix this one and 20:16:23
send you home. 20:16:26
(Indistinguishable.) 20:16:26
DR. SCHATZ: Yeah. We'll talk to 20:55:24
Dr. Botts here because he could do that up there in 20:16:32
Santa Maria. You have had a lot of contrast already. 20:16:35
You have got to be a little careful. The contrast we 20:16:38
gave you, the stuff we inject, that stuff is toxic. 20:16:40
You can't get too much of it. 20:16:43
JL 4 is where? 20:16:54
(Indistinguishable.) 20:16:54
DR. SCHATZ: We'll just do the Levanox. 20:55:24
(Indistinguishable.) 20:55:24
DR. SCHATZ: I'm familiar with it. I know 20:55:24
it's there's some good data, but we don't have any for 20:18:19
stents on it. We know -- 20:18:22
Stop. 20:18:27
-- Levanox works. 20:18:29
I wouldn't do any experimenting. I know 20:18:30
it's a good drug. It looks interesting. Didn't it 20:18:32
just get approved? 20:18:36
(Indistinguishable.) 20:17:47
DR. SCHATZ: Recently, yeah. 20:55:24
Oh. Zitech? Yeah. 20:17:47

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(Indistinguishable.) 20:17:47
DR. SCHATZ: True. Yeah. It's a good 20:55:24
company. I like it. I kind of search for stories 20:18:54
like that where they get bashed inappropriately. It 20:18:57
is always a risk, but. 20:19:00
Little stuff there. Let's just disengage 20:19:09
a little bit. 20:19:15
All right. 20:19:18
Let's have a little nitro. See if we can 20:19:23
make that any bigger. 20:19:27
(Indistinguishable.) 20:19:27
DR. SCHATZ: Yeah. Right. Sure. Yeah. 20:55:24
All right. That looks pretty juicy. 20:19:49
Right that angle down. 20:19:54
Okay. That's all right. Let's get a 20:20:00
stabilizer. 20:20:03
Give me control here. What happened? 20:20:10
Do you have that angle down? 20:20:20
I don't think this will show it. 20:20:28
Yeah. 20:20:34
Oh, that's pretty big. Okay. All right. 20:20:39
Fine. All right. 20:20:42
Oh, we have a Crown here, too. We have it 20:21:02
opened up already. 20:21:05

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One is a 22, though, right? 20:21:06
(Indistinguishable.) 20:21:06
DR. SCHATZ: 20:55:24
Yeah. Do we have a 3.0 balloon? 20:21:11
Anybody's? 20:21:15
(Indistinguishable.) 20:21:15
DR. SCHATZ: Okay. Good. We'll use that 20:55:24
Dupree and then we'll -- here we go. 20:21:20
Got it on tape here. 20:21:23
This is the LAD lesion on the same 20:21:24
patient. 20:21:27
Here we go. Use this to get into the LAD. 20:21:31
Then we'll switch over to the other one. 20:21:36
It doesn't have a circ. That's right. 20:21:45
That's the only place it can go. Right. Let's go. 20:21:47
There you go. Great. Okay. 20:22:46
Do you have an iron man or that XS? 20:22:51
All right. Take the balloon. Then the 20:23:01
iron man next. 20:23:03
All right. Good. 20:23:09
Go. All the way. Good. Stop there. 20:23:29
Iron man. 20:23:58
All right. We're switching out for an 20:24:00
iron man. 20:24:03

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(Indistinguishable.) 20:24:03
DR. SCHATZ: Get this on camera here. 20:24:16
Make sure you see LB here. 20:24:19
This is Lori, who used to work for us. 20:24:24
Lori will be searching for a job. 20:24:32
Tie that in knots. 20:24:40
UNIDENTIFIED SPEAKER: New iron man. 20:24:44
DR. SCHATZ: Let's have a new iron man. 20:24:45
UNIDENTIFIED SPEAKER: Right away. 20:24:50
DR. SCHATZ: Right away. 20:24:54
(Indistinguishable.) 20:25:02
DR. SCHATZ: Blaming me. 20:25:04
Loose. 20:25:14
Pick up. 20:25:15
Forward. 20:25:20
Negative. 20:25:22
Tell me when you're tight. 20:25:30
Good. 20:25:40
All right. Take it up. 2, 4, 6. 20:25:41
UNIDENTIFIED SPEAKER: Going up. 2, 4, 6. 20:25:43
DR. SCHATZ: Okay. Got it. 20:25:47
Get the stents ready. 3.5 by 15 Crown. 20:25:50
Here we go. Loose. Deflate. 20:25:57
Loose and coming out. 20:26:01

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Got a little spasm down there. 20:26:34
(Indistinguishable.) 20:26:39
DR. SCHATZ: Yeah, it does. 20:26:39
Okay. This is 3.0 by 15 Crown. Wow! Use 20:26:41
that as a landmark, that diagonal right after it, and 20:26:45
it will be all right. 20:26:50
(Indistinguishable.) 20:26:38
DR. SCHATZ: Yeah. Good point. 20:26:52
Got a lot of spasm down there. I hope 20:26:55
that's spasm. 20:26:58
It's a stiff wire. There is a curve down 20:27:01
there. Actually that could be pseudo stenosis, too. 20:27:03
Okay. Go ahead. Any time. Go. 20:27:09
Okay. When this goes in, we'll switch the 20:27:16
wire out for a stabilizer. See if that all goes away. 20:27:18
(Indistinguishable.) 20:27:33
DR. SCHATZ: Yeah, I will in a second. 20:27:33
Okay. And -- okay. This is a 3.0 by 15 20:27:34
Crown, which goes nicely. 20:27:41
Forward. And negative. 20:27:51
(Indistinguishable.) 20:27:33
DR. SCHATZ: Right. 20:27:33
(Indistinguishable.) 20:27:33
DR. SCHATZ: Yeah. A little more distal. 20:28:10

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(Indistinguishable.) 20:27:33
DR. SCHATZ: A little more distal. 20:28:12
Let's put a hundred up. Good. 20:28:15
All right. Take it up, 2, 4, 6. 20:28:18
UNIDENTIFIED SPEAKER: Going up. 2, 4, 6. 20:28:18
DR. SCHATZ: 8, 10. 20:28:23
UNIDENTIFIED SPEAKER: 8, 10. 20:28:23
DR. SCHATZ: 12, 14. 20:28:24
UNIDENTIFIED SPEAKER: 12, 14. 20:28:24
DR. SCHATZ: Good. 20:28:26
(Indistinguishable.) 20:28:26
DR. SCHATZ: Yeah. Deflate. Okay. 20:28:27
Let's run it down a little bit, if it will 20:28:30
go. Let's have a new wire, too. A stabilizer. 20:28:32
(Indistinguishable.) 20:28:32
DR. SCHATZ: I don't know how far it will 20:28:42
go. That's fine. That's good enough. 20:28:42
All right. Stabilizer. 20:28:42
UNIDENTIFIED SPEAKER: The stabilizer is 20:28:43
in. 20:28:44
DR. SCHATZ: Actually before it goes in, 20:29:12
let's take a picture, before we go anywhere down 20:29:13
there. Go ahead. 20:29:17
That's occlusive there. That might be a 20:29:32

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tear down there. Watch out. 20:29:33
Wire. Let me have the torquer. 20:29:35
Could be a tear down there.
(Indistinguishable.)
DR. SCHATZ: Yeah. Could be.
Get the test shots there.
Yeah. That is a problem there.
Okay. Loose. Let's bring it back. 20:29:41
Let's have a little nitro. It's got some 20:30:13
STs that are funky there. 20:30:21
Fluids up to 500. 200 of nitro. 20:30:21
All right. Here we go. 20:30:32
That doesn't look very good there. Some 20:30:44
problems there. 20:30:47
Breathe away. 20:30:49
(Indistinguishable.) 20:31:00
UNIDENTIFIED SPEAKER: Not yet. 20:31:00
DR. SCHATZ: Get that wire a little bit. 20:31:01
Let's take this out. 20:31:03
Try to manipulate the wire a little bit 20:31:06
while I got it. 20:31:09
A little test shot see if I can find the 20:31:12
true lumen^ spg down there. 20:31:16
Test any time. 20:31:20

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The distal I need to see there. It's 20:31:25
looking better already. 20:31:29
Okay. Loose. 20:31:36
Yeah. That's better. Loose and coming 20:31:37
out. 20:31:40
I don't know. Might be all right. I 20:31:46
think just had to get the -- I think the wire just 20:31:52
tickled it maybe and the nitro finally worked. 20:31:53
Yeah. Spasm. All right. 20:32:16
Okay. That's a 3.0 Crown there. It looks 20:32:22
absolutely perfect. We had a little spasm, which is 20:32:25
already better. 20:32:29
That's going to be a final. 38 and 45 go 20:32:30
together. Plus 4 minus 23. 20:32:34
Take a deep breath and hold it. Good. 20:32:44
Hold that breath. Don't breathe and don't move. 20:32:47
That's nice. 20:32:52
Breathe away. 20:32:54
I don't know if he had something there 20:32:58
already in that distal. 20:33:00
(Indistinguishable.) 20:33:00
DR. SCHATZ: Go back to 39. Scroll back 20:33:07
to 39. No. 20:33:11
(Indistinguishable.) 20:33:11

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DR. SCHATZ: I still don't know if that's 20:33:30
spasm, or. 20:33:32
(Indistinguishable.) 20:33:32
DR. SCHATZ: Yeah, a little bit. Mm-hmm. 20:33:40
The wire did jam down there momentarily. 20:33:47
All right. We may just have to -- all the wire is 20:33:50
there. Yeah. 20:33:54
(Indistinguishable.) 20:33:54
DR. SCHATZ: 2.5 probably, or longer. 20:33:58
(Indistinguishable.) 20:33:58
DR. SCHATZ: Bring a 40 also. I'm not 20:34:11
sure what it's going to be. 20:34:13
(Indistinguishable.) 20:34:13
DR. SCHATZ: Yeah. 20:34:19
As long as we have the wire there, let's 20:34:19
just do another one. 20:34:22
(Indistinguishable.) 20:34:22
DR. SCHATZ: Yeah. I don't know what 20:34:22
length yet, though. 20:34:44
It's a 40. Give me the 40. 20:34:44
It's probably just two atmospheres. Just 20:35:00
two atmospheres. If it's spasm, it could break also. 20:35:03
Okay. Go. 20:35:37
Stop. Go. Good. 20:35:53

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Okay. Just a shade farther. Not much. 20:36:16
Yeah. 20:36:31
All right. Take that up to 2. All right. 20:36:32
All right. So we stented the -- 20:36:35
(Indistinguishable.) 20:36:35
DR. SCHATZ: Looks like spasm. I can't 20:36:40
tell. Just the distal all of a sudden went ... So 20:36:42
if it's spasm, it should break with this. It could be 20:36:49
a little wire tear, although the wire didn't 20:37:22
misbehave. 20:37:26
Okay. We have a 2.5 by 40 predator. 20:37:26
Trying to touch up this distal stuff, distal to the 20:37:29
stent. It's either spasm or a little tear, but I 20:37:33
think it's going to be okay. Rather than take 20:37:37
everything out, we'll just do a nice, long, low 20:37:42
inflation, see if it gets better. 20:37:44
ACT^ spg syringe. 20:37:48
What was the last one? 20:37:52
(Indistinguishable.) 20:37:52
DR. SCHATZ: Okay. Time. 20:37:57
All right. Deflate. Okay. 20:38:58
(Indistinguishable.) 20:38:58
DR. SCHATZ: Don't replace that contrast 20:39:05
yet. We might be done. 20:39:06

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Tight. Let's have a little more nitro. 20:39:15
The guide is in. 20:39:31
Now we're out of contrast. This is our 20:39:38
4-inch or 5. 20:39:42
Okay. 20:39:49
Try it without the wire. Yeah. Drop some 20:39:51
in a cup. 20:39:58
Trying to save money here, Sam, so I don't 20:40:00
have to open up another bottle. 20:40:03
Always thinking to save John Armstrong 20:40:06
money. You piece of shit. 20:40:10
(Indistinguishable.) 20:40:10
DR. SCHATZ: Trying to keep it under a 20:40:12
million dollars. 20:40:13
Okay. One last bit. 20:40:16
All right. I think it's going to be okay. 20:40:30
All right. I think that's okay. I don't 20:40:38
know if that was spasm or a little damage there, but 20:40:41
it looks all right. 20:40:45
I don't know. 20:40:49
(Indistinguishable.) 20:40:49
DR. SCHATZ: Yeah, yeah. I think it's 20:40:53
spasm. It will get better. 20:40:59
Okay. That will be a final. Just put 38, 20:41:02

or 39 with 49. 20:41:05
Take it out. All right. We're done. 20:41:08

20:15:39 18:8
20:15:43 18:9
20:15:44 18:10
20:15:47 18:11
20:15:52 18:12
20:15:55 18:13
20:15:59 18:14
20:16:04 18:15
20:16:06 18:16
20:16:07 18:17
20:16:09 18:18
20:16:12 18:19
20:16:14 18:20
20:16:18 18:21
20:16:19 18:22,23
20:16:23 18:24 19:1
20:16:26 19:2,3
20:16:32 19:5
20:16:35 19:6
20:16:38 19:7
20:16:40 19:8
20:16:43 19:9
20:16:54 19:10,11
20:17:47 19:22,24 20:1
20:18:19 19:15
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20:18:27 19:17
20:18:29 19:18
20:18:30 19:19
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20:18:36 19:21
20:18:54 20:3
20:18:57 20:4
20:19:00 20:5
20:19:09 20:6
20:19:15 20:7
20:19:18 20:8
20:19:23 20:9
20:19:27 20:10,11
20:19:49 20:13
20:19:54 20:14
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